Examining Employee Preferences for Workplace Wellbeing Intervention Designs

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Abstract

It is widely recognised that optimising the health and wellbeing of employees has benefits at both the individual and organisational level, yet wellbeing interventions often have disappointing participation levels. Employee perceptions of interventions are understood to impact participation levels. The purpose of the current study was to explore employee perceptions of four types of wellbeing interventions, which differed from each other with regard to who leads the intervention (employee vs organisation) and if it is related to, or independent from, the work itself. 92 individuals in full-time employment in New Zealand participated in an online survey, where they rated vignettes outlining different interventions along the following evaluation criteria: intention to participate, sustained participation intention, perceived effectiveness to the individual, and perceived effectiveness to the organisation. Participants then rank-ordered the interventions in order of preference. The results show that while participants did not show any clear preference for an intervention type, the work-independent organisation-led intervention was rated significantly less favourably in comparison to the other interventions along all evaluation criteria. Furthermore, most individuals ranked work-independent organisation-led as the least preferred intervention type. These findings suggest that organisation-led work-independent interventions are not perceived as positively as other possible intervention types, which is unfavourable given these are the interventions most often implemented. Though preliminary, the findings may inform practitioners and organisations to select or design wellbeing interventions that promote buy-in and engage employees such that participation rates may increase.

Introduction

New Zealand employees are experiencing increasing levels of stress and anxiety (BusinessNZ & Southern Cross Healthcare Society, 2019). Work-related anxiety, stress, and depression as a cause for absence from work has increased from 6.4% in 2016 to 22.2% in 2018. We spend much of our time at work, so many stressors of life are tethered to our job roles and organisational environment. Thus, the workplace has been recognized as an optimal place to target the promotion of health and wellbeing (Grawitch, Ballard, & Erb, 2015; Kumar et al., 2009). In order to do so, organisations can implement wellbeing interventions.

There are many benefits to both individuals and organisations that are associated with the implementation of wellbeing interventions. Individuals who are healthy can contribute to the workplace with a better ability to produce higher quality work, cope with pressure and change, and achieve organisational goals (Sullivan, 2004). Research shows that individuals who participate in wellbeing interventions may experience reduced stress (Abdullah & Lee, 2012), anxiety, and burnout (Brown et al., 2011). Further individual benefits include greater job satisfaction (Abdullah & Lee, 2012; Parks & Steelman, 2008), increased resilience (Hartfiel et al., 2011), weight reduction, and increased physical fitness and stamina (Dejoy et al., 2012). Organisations may experience improvements in recruitment, teamwork (Bakker, 2015), communication, employee morale, productivity, and retention. Rath and Harter (2010) estimate that for every US dollar spent on wellbeing there is a 5 US dollar return on investment. Benefits relating to return on investment may include reduced turnover, reduced sickness absences (Kuoppala et al., 2008), reduced absenteeism (Abdullah & Lee, 2012; Parks & Steelman, 2008) and presenteeism (Cancelliere et al., 2011), lower healthcare costs, and fewer accidents (Keyes & Grzywacz, 2005; Nielsen & Abildgaard, 2013). Additionally, individuals employed in workplaces that offer interventions feel greater organisational support and are more likely to

recommend their organisation as a positive place to work to others (Kumar et al., 2009). In order to reap these benefits the proportion of the workplace that participates in the intervention must be high.

Current low participation rates in wellbeing interventions, which typically appear below 50% (Robroek et al., 2009), undermine their effectiveness and rigorous evaluation, and may decrease the generalizability of intervention results (Linnan et al., 2001; Robroek et al., 2009). Both initial employee input (i.e. in planning phases) and sustained participation rates (i.e. throughout implementation) are essential to ensure successful intervention outcomes (Nielsen et al., 2007; Nielsen & Randall, 2012; Person et al., 2010; Robroek et al., 2012). Employee input into intervention design and implementation ensures a good fit between the intervention, employee needs, and the organisation's context and culture by making use of important employee knowledge to integrate activities into existing structures and initiatives (Lamontagne et al., 2007; Nielsen & Randall, 2012). Such information supplements the knowledge of expert consultants (LaMontagne et al, 2007), and in addition to increasing feelings of ownership over interventions, may contribute to the development of interventions that ensure sustained participation (Seaton et al., 2017). Current literature identifies individual, organisational, and intervention factors affecting participation, for example time constraints, current health status, and managerial support respectively (e.g. Jørgensen, Villadsen, Burr, Punnett, & Holtermann, 2016; Robroek et al., 2009). Yet, the impact of intervention design on employee participation and intervention success remains largely unexamined.

Street and Lacey (2018) suggest that employee views of wellbeing interventions should inform their design, as these individuals are in a better position to appraise the suitability of interventions to personal, role, and organisational needs. Yet, wellbeing interventions tend to be designed and implemented based upon the opinions of expert consultants and senior

managers, with minimal employee involvement in planning stages (Goetzel et al, 2007). Thus, blanket interventions that typically disregard the employees' perspectives on design, delivery, and content are often implemented where cost is the main driving factor as opposed to engagement and outcomes (Street & Lacey, 2018). Employee perceptions and appraisals of interventions are important in determining participation levels and subsequently successful intervention outcomes (Nielsen et al., 2007; Street & Lacey, 2018). Positive employee perceptions may at the very least lead to increased motivation to participate in a specific intervention (Goetzel et al., 2007; Rongen et al., 2014; Spence, 2015), and those perceived as more effective may lead to increased sustained participation (Street & Lacey, 2018). Rongen and colleagues (2014) are among the few to investigate employee perceptions with regard to wellbeing interventions, and found that employees had greater intention to participate in an intervention given they possess a positive attitude toward them, have high social support and self efficacy, and if they perceive their health status to be less than good. Nielsen and Abildgaard (2013) suggest it is relevant to examine perceptions of the quality and sustainability of intervention activities. Thus, organisations are more likely to secure ongoing employee participation by ensuring that the interventions are viewed as interesting, useful, feasible, and not infringing on role demands (Nielsen et al., 2007), and by developing high quality interventions that are both relevant and appropriate to the needs of the employees (Goetzel et al., 2007; Nöhammer et al., 2011).

The aim of the current study is to assess employee perceptions of, and preference for, different wellbeing intervention designs. Aspects of intervention design explored include who leads the decision making and implementation processes of interventions (employees vs the organisation) and if the intervention is related to, or independent of, the work itself. Four vignettes were developed such that each one outlined a different combination of employee-led

vs organisation-led, and work-independent vs work-related wellbeing activities. These interventions were evaluated by the participants using a survey. Participants evaluated each of the four interventions on the following criteria: intention to participate, belief in sustained participation, effectiveness of the intervention to the individual, and effectiveness of the intervention to the organisation.

Literature Review

Wellbeing Interventions

Numerous definitions of wellbeing exist in the literature. Scholars are yet to come to a consensus on how to best define wellbeing, however it is widely accepted as a multidimensional construct. Wellbeing can be understood by combining eudaimonic and hedonic perspectives (Keeman et al., 2017). The eudaimonic perspective emphasizes the need for individuals to find meaning and virtue by engaging in activities that promote growth and self-actualization (e.g. autonomy, mastery) to enhance wellbeing (Ryan & Deci, 2001). In contrast, the hedonic perspective regards wellbeing as greater happiness and life satisfaction (Ryan & Deci, 2001). Hence, wellbeing encompasses optimal psychological functioning with feelings of positivity and satisfaction (Keeman et al., 2017).

The job demands-resources model (JD-R; Bakker & Demerouti, 2007; Demerouti et al., 2001) considers wellbeing in an organisation context. According to the JD-R, optimal employee wellbeing is an output of a balance between an individual's perceived job demands and resources. Job demands include psychological, social, physical, and organisational stressors that require sustained effort and subsequently are associated with some cost (Bakker & Demerouti, 2014). Demands can thus lead to stress, fatigue, negative affect, and related health problems, and may eventually result in burnout. Sauter, Murphy, and Hurrell (1990)

identified six stressors as consistent in the literature, including workload and pace, role stressors (role conflict, role ambiguity), career concerns, work schedules, interpersonal relationships, and job content and control. Stressors including low decision latitude, low social support, high psychological demands (e.g. work pressure), effort-reward imbalance, and high job insecurity have all been identified as causes or work stress-related anxiety and depressive illnesses (Stansfeld & Candy, 2006). These health problems are in turn related to organisational outcomes, such as poor performance, absenteeism, and sickness.

A healthy workplace is considered to benefit the employee by preventing or mitigating the effects of demands whilst optimising organizational outcomes (Grawitch et al., 2007). This can be achieved through the provision of resources (Bakker & Demerouti, 2014). Resources include psychological, social, physical, and organisational aspects that reduce job demands and hence minimise their detrimental outcomes, support the achievement of organisational goals, or promote individual learning, development and growth (Bakker & Demerouti, 2014). JD-R theory identifies both job and personal resources. Examples of job resources may include career opportunities, social support, autonomy, and performance feedback. Personal resources may be considered individual self-evaluations that are linked to resiliency and an individuals' ability to control and impact upon their environment, for example self-efficacy and coping strategies (Bakker & Demerouti, 2014).

Organisations can foster a healthy workplace through the implementation of wellbeing interventions which may provide supportive resources that can minimize or mitigate the negative effects of job demands. The term "wellbeing intervention" is defined as any initiatives, programmes, or practices that aim to improve or promote the physical, psychological, and social health and wellbeing of individuals. These interventions foster wellbeing such that employees experience higher levels of thriving in response to challenges in the workplace

(Bakker & Demerouti, 2008). Given organisations vary greatly in environment and culture, there is no 'one size fits all' intervention. Further, successful interventions differ greatly in design from organisation to organisation.

Wellbeing interventions can be classed as primary, secondary, or tertiary (Grawitch et al., 2015). Primary interventions aim to be proactive by changing the workplace and its demands in a preventative manner so as to manage job stressors and mitigate their negative impact on employee health and wellbeing e.g. job crafting, leadership development. Secondary interventions are ameliorative in that they target, although are not limited to, those who are already at risk, aiming to change their perception of, or reaction to a stressor (Goetzel & Ozminkowski, 2008), e.g. meditation, stress management. Tertiary interventions are reactive, dealing with the aftermath of stress and strain e.g. EAP. Activities and initiatives implemented at any of these levels may differ with regard to who they target (individual or organisation) or if they are related to, or alternatively independent from, the work itself. For the purpose of this study aspects of design that are covered include primary (labelled as work-related) and secondary (labelled as work-independent) interventions.

Work-related interventions

Work-related interventions reflect primary interventions aimed at changing the way work is designed, organised, planned and managed, such that job demands and resources are balanced (Nielsen & Abildgaard, 2013). These interventions may encompass sociotechnical or psychosocial changes (LaMontagne et al., 2007). Sociotechnical interventions include changes to physical working conditions i.e. workload, work schedules and work processes. Changes in work procedures have been associated with improved post-intervention working conditions and employee well-being (Nielsen & Randall, 2012). Alternatively, psychosocial interventions aim to change employee perceptions of the work setting through initiatives such

as training, team development, and work redesign (Kelloway et al., 2008). The JD-R highlights that well-designed jobs and optimal working conditions can facilitate employee wellbeing (Bakker & Demerouti, 2014). For example, making changes to job design, scheduling and workflow is considered best practice in order to reduce employee work-related stress (Gibson & Quick, 2007). Furthermore, job sharing, work-at-home practices, and flexible work hours have been related to reducing worker stress (Härenstam & MOA Research Group, 2005). Thus, making changes to work processes as the intervention itself, may produce higher participation rates (Jørgensen et al., 2016), subsequently ensuring associated benefits can be reaped by organisations and individuals.

Work-independent interventions

Work-independent interventions reflect secondary interventions, and may include stress management or health promotion initiatives. With reference to the JD-R, such interventions are aimed at modifying employee perceptions of and reactions to stressors (LaMontagne et al., 2007). In turn, this increases an individual's personal resources, such as resilience, in order to enable them to deal with job demands (Randall & Nielsen, 2010). Stress management interventions provide information and tactics to increase personal resources to enable employees to cope with their work stress, including meditation, exercise, and interpersonal skills training (Kelloway et al., 2008; Parks & Steelman, 2008). Health promotion interventions seek to either increase awareness (e.g. through health fairs, blood pressure screening, posters), elicit behavioural change (e.g. losing weight, increasing physical fitness), or create a workplace that promotes a healthy lifestyle (e.g. offering healthy foods, providing bike racks) (Kelloway et al., 2008). Larsson, Setterlind and Starrin (1990) found that secondary interventions improve employee personal resources, which can transfer to workplace attitudes and behaviours and thus improve overall wellbeing. Additionally, interventions that build

individual resources may also enable employees to better respond to organisational change, which is often a stress-inducing process (Shin et al., 2012).

Work-independent interventions traditionally dominate the workplace and are more frequently implemented than work-related interventions, however research suggests the latter are more effective in improving wellbeing and other outcomes (Kelloway & Day, 2005; LaMontagne et al., 2007, Noblet & LaMontagne, 2006). In line with the "hierarchy of controls", which states that the further upstream one is from adverse health outcome, the greater the prevention effectiveness, primary preventions will generally be more effective than secondary (LaMontagne et al., 2007), and should be first priority where possible (Nielsen & Abildgaard, 2013). Work-independent interventions are considered less effective as a result of being too general (Kelloway et al., 2008), and only reducing the symptoms of the problems (e.g., stress levels) rather than addressing the cause (e.g., specific stressor) (Vézina et al., 2004). Moreover, individual-level interventions do not have favourable impacts at the organisational level, whereas organisation-level interventions favourably impact both individual and organisational outcomes (LaMontagne et al., 2007). Interventions that target the organisational level, such as changes to job features, are thought to be more sustainable than those that target individual wellness, and show long-term effects on employee health and wellbeing (Montano et al., 2014). Even though research identifies work-related interventions as more effective, work-independent interventions may be implemented more frequently due to the perceived high costs and logistical complexity associated with primary interventions (Kelloway et al., 2008). Initiatives that are related to work may be better received by employees, given that they address the root cause of the stress are seen as relevant in a work setting. Furthermore, in a New Zealand context work-related interventions may be more attractive as they can target the main cause of stress in the workplace: high workload (BusinessNZ & Southern Cross

Healthcare Society, 2019). Thus, though both work-related and work-independent interventions are uniquely advantageous in promoting wellbeing, employees may favour work-related interventions.

Employee involvement in interventions

Research widely identifies involvement as particularly important during the intervention planning and implementation phases in determining successful outcomes (Grawitch et al, 2015; Nielsen et al, 2010; Tafvelin et al., 2019). Interventions comprise needs assessment, design and development, implementation, and evaluation stages, all of which offer opportunity for employee involvement (Grawitch, Ledford, Ballard, & Barber, 2009). The degree to which employees may be involved in interventions varies on a continuum from low involvement (e.g., management-driven initiates) to high involvement (e.g., self-management). Employee input and involvement are widely considered an essential element of interventions (Quick et al., 2014). Making use of employee expertise may ensure relevance of interventions (Peersman et al., 1998) and improve chances of success (Kompier et al., 2000). Grawitch, Ballard, and Erb (2015) argue that high involvement is the most beneficial, as this may influence active participation in initiatives and may cause employees to take responsibility for initiative outcomes. Nevertheless, the authors also note it is important to meet the employees' *desired level* of involvement, which may not necessarily be high involvement, nor be the same for different workplaces. Employee satisfaction with the level of involvement in interventions has been linked to intervention outcomes, for example organisational commitment, in addition to healthy workplace outcomes such as growth and development, recognition, and work life balance (Grawitch et al., 2007). Furthermore, interventions devised according to the desired degree of involvement may foster the experience of agency and collective efficacy (Bandura,

2000). For the purpose of this study, low involvement (labelled as organisation-led) and high involvement (labelled as employee-led) are covered.

Organisation-led interventions

In the context of this study, "organisation-led" interventions are defined as those where senior leaders drive the decision-making and implementation processes. Typically, senior management make strategic decisions involved with interventions (Nielsen & Abildgaard, 2013). On one hand, organisations that lead interventions could be perceived as showing increased top management support, and as being more caring about their employees. Numerous researchers argue the importance of top management support in intervention success (Grawitch et al., 2015; Kohler and Munz, 2006; Nielsen & Abildgaard, 2013), as top management attitudes may influence intervention outcomes (Dahl-Jørgensen & Saksvik, 2005). Conversely, organisation-led interventions could be perceived as the organisation simply trying to 'tick a box', or offering interventions simply as a benefit for the organisation rather than its employees (Spence, 2015). Employees may not trust the organisation in terms of its motives, integrity, and ability to meet obligations in relation to offered interventions, and may perceive the intervention as a veiled form of corporate social control (Spence, 2015). Furthermore these interventions may cause participants to not feel ownership for the intervention initiatives, making it difficult to ensure a long-lasting effect (Dahl-Jørgensen & Saksvik, 2005). Research thus postulates that employees may prefer to take on the responsibility of leading interventions themselves, so long as their senior leaders show support (Grawitch et al., 2015).

Employee-led interventions

"Employee-led" interventions are defined as those where employees drive the planning and implementation processes. By leading the planning and implementation of interventions, employees may establish increased responsibility, ownership and commitment toward the

intervention (Grawitch et al., 2015; Peersman et al., 1998; Rosskam, 2018; Tafvelin et al., 2019), and hence minimize the risk that the process stagnates (Nielsen et al, 2010). This furthermore may decrease the likelihood that intervention success depends on a small group of senior leaders or external consultants and thus has a better chance at bringing about sustainable changes (Nielsen et al, 2010). Nielsen, Randall and Albertsen (2007) found influence over intervention content to be a predictor of intervention outcomes, including reducing stress and increasing job satisfaction. Employees may show a preference for employee-led interventions due to feeling empowered (Nielsen & Randall, 2012b), experiencing an element of respect and esteem from the organisation (Andersen & Svarer. 2007), and satisfaction of employee needs to feel both heard and valued (Semmer, 2006). Delegating this responsibility to the employees may also increase the sense of fairness and justice felt by employees (Nielsen et al, 2010). Influence over the content of an intervention is a predictor of participation in intervention activities (Nielsen et al., 2007). For example Aust, Rugulies, Finken, and Jensen (2010) found that employees reacted negatively to having limited influence over the scope of an intervention, and subsequently did not participate in intervention activities. This would suggest that employees may respond positively to leading interventions, as they are granted full control (Nielsen et al., 2007). Giving employees this control may act as an intervention in itself, given that greater control in the work environment and decision making has consistently been linked to increased wellbeing in employees (Boxall & Macky, 2014; Eatough & Spector, 2014). It is thus predicted that employees will show a preference for interventions that are work-related rather than work-independent, and employee-led rather than organisation-led. As such, the following were hypothesised:

H1: Intention to participate in wellbeing interventions will be significantly higher for employee-led, work-embedded interventions than for other intervention designs

H2: Belief in sustained participation in wellbeing interventions will be significantly higher for employee-led, work-embedded interventions than for other intervention designs

H3: Perceptions of effectiveness of the wellbeing intervention to the individual will be significantly higher for employee-led, work-embedded interventions than for other intervention designs

H4: Perceptions of effectiveness of the wellbeing intervention to the organisation will be significantly higher for employee-led, work-embedded interventions than for other intervention designs

H5: Employee-led, work-embedded interventions will be ranked as the most preferable in comparison to other intervention designs

Method

Participants

Eligible participants were individuals over 18 years of age and currently employed full-time in New Zealand. To preserve anonymity, age and gender were the only demographic variables collected. Of the 124 individuals who accessed the survey, data from 35 participants were deleted for nonresponse, leaving a final sample of 92 participants. A majority of participants had not previously participated in a workplace wellbeing intervention (82%, n=75). The sample comprised 23 males, 51 females, 3 gender diverse, and 15 unspecified. The age of participants ranged from 22 to 60 years (M = 30.69, SD = 11.91).

Materials

Interventions

Participants were presented with a description of four different interventions including one each of work-independent, employee-led; work-related, employee-led; work-independent, organisation-led; and work-related, organisation-led, as follows:

Work-independent Employee-led. Your organisation is offering you and your team the chance to **help design an intervention to improve wellness**. The intervention will consist of a series of initiatives trialled over an 8-week period and participation is entirely voluntary. This will be a collaborative process whereby your organisation will provide a team of consultants to look into **current stressors experienced by employees to identify specific activities to be offered to improve wellness in the workplace**. The consultants will be tasked with compiling information and running a brainstorming session with staff where they will be available to offer their expertise, but **ultimately you and your team will decide upon the design and implementation of the initiatives**. Activities to be implemented could include yoga classes, stress management courses, tai chi classes, mindfulness courses, and so on

Work-related, Employee-led. Your organisation is offering you and your team the chance to **help design an intervention to improve wellness**. The intervention will consist of a series of initiatives trialled over an 8-week course and participation is entirely voluntary. This will be a collaborative process whereby your organisation will bring in a team of consultants to look into **current work processes and identify ways in which these aspects can be changed to improve wellness in the workplace**. The consultants will be tasked with compiling information and running a brainstorming session with staff where they will be available to offer their expertise, but **ultimately you and your team will decide upon the design and implementation of the initiatives**. Initiatives linked to improved work processes

and culture may include introducing walking meetings, designating a space for relaxation, increasing autonomy, introducing more frequent breaks, and so on.

Work-independent, Organisation-led. Your organisation is offering you and your team the chance to **partake in an initiative to improve wellness**. The initiative will be trialled over an 8-week period and participation is entirely voluntary. This will be a collaborative process whereby your organisation will provide a team of consultants to look into **current stressors experienced by employees to identify specific activities to be offered to improve wellness in the workplace**. You are invited to **fill out a 15-minute survey where you can provide information concerning current stressors you experience at work along with suggestions for improvement**. The information you provide may be used by the experts to inform the specific activities to be implemented. Activities to be implemented could include yoga classes, stress management courses, tai chi classes, mindfulness courses, and so on

Work-related, Organisation-led. Your organisation is offering you and your team the chance to **partake in an intervention to improve wellness**. The intervention will consist of a series of initiatives trialled over an 8-week period and participation is entirely voluntary. This will be a collaborative process whereby your organisation will bring in a team of consultants to look into **current work processes and identify ways in which these aspects can be changed to improve wellness in the workplace**. You are invited to **fill out a 15-minute survey where you can provide information concerning current stressors you experience at work along with suggestions for improvement.** The information you provide may be used by the experts to inform changes to work processes. Initiatives linked to improved work processes and culture may include introducing walking meetings, designating a space for relaxation, increasing autonomy, introducing more frequent breaks, and so on.

Measures

Previous participation in a wellbeing intervention was assessed using the item "have you previously participated in a workplace wellbeing intervention?". The response options were "yes" and "no".

Intention to participate was used as a measure of behaviour intent, with a single item "If my organisation offered this intervention I would participate". This was assessed on a 5-point Likert scale from 1= strongly disagree to 5 = strongly agree such that a high score corresponded to greater intention to participate in the intervention.

Sustained participation intention, i.e. the subjective likelihood that an individual would participate in the intervention activities until completion, was rated using a Likert scale from strongly disagree (1) to strongly agree (5), as with perceived effectiveness. A high score represented greater perceived sustainability. A single item, "I can see myself participating in this intervention in the long run", was used.

Perceived effectiveness, i.e. the subjective likelihood that the intervention would make a positive impact, was assessed from the perspective of impact on the individual, and impact on the organisation. The former was assessed with the item "this intervention would improve my wellness" and the latter with the item "this type of intervention would improve the wellness of my organisation". Both were rated using a Likert scale with 1 = strongly disagree, 2 = agree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree, such that a high score represented greater perceived effectiveness.

Procedure

The design of the study was within-subjects repeated measures such that each participant assessed and ranked the four interventions at one time point. Participants were

recruited via snowballing through the platforms of Linkedin and Facebook where a direct link to an online questionnaire administered on Qualtrics was posted (Appendices A and B). The online questionnaire included an information and consent form which participants agreed to before continuing the questionnaire. Participants completed the questionnaire in their own time and participation was voluntary. The questionnaire first assessed if employees had previously taken part in a workplace wellbeing intervention. Participants were then asked to carefully read and rate four different hypothetical interventions along the following criteria: intention to participate, sustained participation intention, perceived individual effectiveness, and perceived organisational effectiveness. Participants were then asked to rank order the interventions from their most preferred to their least preferred. Finally demographic information was requested including age, and gender (coded as male=1, female=2, or gender diverse=3). An incentive to participate was provided such that employees could enter a draw to win one of 5x $200 supermarket vouchers following completion of the questionnaire. To preserve anonymity, participant information for the prize draw was collected on a separate webpage to the online questionnaire. This personal information was used only for the distribution of prizes and was destroyed at the completion of the study.

Results

Individual differences in intervention ratings

Independent samples t-tests were carried out to identify gender differences in ratings of interventions along the criteria of interest. Differences were found among the ratings of interventions 2 (organisation-led, work-related) and 3 (employee-led, work-independent). Women rated intervention 2 significantly higher than men in the criterion of intention to

participate [t = -2.4 p < .05, 95% CI (-.89, -.08)], sustained participation intention [t = -2.15, p < .05, 95% CI (-.84, -.03)], and perceived individual effectiveness [t = -2.9, p < .01, 95% CI (-1.02, -.18)]. At the less stringent significance level of .10, females rated intervention 2 higher than males in the criterion of organisational effectiveness [t = -1.78, p < .01, 95% CI (-.78, .05)], and intervention 3 in the criterion of intention to participate [t = -1.82, p < .01, 95% CI (-.96, .05)]. These results suggest gender differences where in comparison to males, females prefer work-related interventions but only when the organisation leads them, and will instead opt to lead interventions that are work independent.

Bivariate correlations were calculated to explore the relationship between participant age and ratings of interventions along the criteria of interest (Table 1). Age was negatively correlated with perceived effectiveness of intervention 1 (employee-led, work-related) to the individual (r = -.24, p , .05) and to the organisation (r = -.23, p < .05). Similarly, age was negatively correlated with perceived effectiveness to the individual, (r = -.24, p < .05) and to the organisation (r = -.24, p < .05) for intervention 3 (employee-led, work-independent). This suggests that younger participants perceive employee led interventions to be all over more effective than older generations. Additionally, age was negatively correlated with intention to participate (r = -.26, p < .05) in intervention 4 (organisation-led, work independent). These results suggest intergenerational differences, with younger participants classifying wellbeing interventions more favourably with regard to specific criteria. These findings will be discussed in greater detail in the next section.

Hypothesis Testing

General linear models were conducted to test whether participants assigned significantly different scores to the four wellbeing interventions, and pairwise comparisons

Table 1. Correlations between all variables and age

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.
1. Age	-																
Participation																	
2. Intervention 1	-.16	-															
3. Intervention 2	-.03	.56**	-														
4. Intervention 3	-.20	.74**	.53**	-													
5. Intervention 4	-.26*	.50**	.56**	.62**	-												
Sustained participation																	
6. Intervention 1	-.11	.83**	.59**	.70**	.44**	-											
7. Intervention 2	-.03	.43**	.61**	.30**	.50**	.52**	-										
8. Intervention 3	-.21	.65**	.53**	.86**	.59**	.71**	.30**	-									
9. Intervention 4	-.05	.21	.25*	.23*	.48**	.19	.25*	.24*	-								
Individual effectiveness																	
10. Intervention 1	-.24*	.70**	.37**	.47**	.38**	.71**	.53**	.45**	.06	-							
11. Intervention 2	-.09	.37**	.66**	.34**	.47**	.44**	.66**	.37**	.26*	.34**	-						
12. Intervention 3	-.24*	.47**	.25*	.67**	.55**	.47**	.28*	.67**	.13	.60**	.27*	-					
13. Intervention 4	-.06	.21	.09	.33**	.43**	.20	.33**	.27*	.52**	.27&	.18	.45**	-				
Organisation effectiveness																	
14. Intervention 1	-.23*	.60**	.32**	.42**	.31**	.59**	.41**	.45**	.20	.80**	.33**	.52**	.33**	-			
15. Intervention 2	-.03	.44**	.70**	.43**	.49**	.45**	.54**	.45**	.42**	.33**	.71**	.34**	.37**	.40**	-		
16. Intervention 3	-.24*	.46**	.32**	.70**	.56**	.47**	.29**	.68**	.34**	.53**	.23*	.81**	.55**	.58**	.40**	-	
17. Intervention 4	-.21	.48**	.43**	.55**	.66**	.41**	.43**	.52**	.41**	.46**	.38**	.67**	.59**	.49**	.51**	.73**	-

Note. * Significant at p= <0.05. ** Significant at p= <0.01. Intervention 1 = employee-led, work-related. Intervention 2 = organisation-led, work-related. Intervention 3 = employee-led, work independent. Intervention 4 = organisation-led, work independent.

Table 2. Descriptive statistics and summary of significant mean differences within criteria and between mean ratings of intervention 4 and the other intervention design types

	F	Partial Eta squared	M	SD	Mean difference	SE	95% Confidence Intervals for Mean difference	
							Lower	Upper
Participation	50.85**	.68						
Intervention 1			4.08	1.06	-.87*	.11	-1.10	-.64
Intervention 2			4.20	0.85	-.99*	.09	-1.17	-.80
Intervention 3			4.09	1.02	-.88*	.10	-1.07	-.69
Intervention 4			3.21	0.86	-	-	-	-
Sustained participation	14.00**	.37						
Intervention 1			3.81	1.06	-.65*	.16	-.97	-.33
Intervention 2			4.04	0.87	-.88*	.14	-1.16	-.60
Intervention 3			3.86	1.04	-.70*	.15	-1.00	-.40
Intervention 4			3.16	1.06	-	-	-	-
Individual effectiveness	29.15**	.56						
Intervention 1			3.88	1.01	-.86*	.13	-1.13	-.60
Intervention 2			3.90	0.93	-.89*	.13	-1.15	-.63
Intervention 3			4.03	0.97	-1.01*	.11	-1.24	-.79
Intervention 4			3.01	0.83	-	-	-	-
Organisation effectiveness	102.33**	.81						
Intervention 1			3.95	0.91	-.91*	.10	-1.10	-.71
Intervention 2			4.07	0.92	-1.03*	.10	-1.22	-.83
Intervention 3			4.08	0.92	-1.04*	.07	-1.18	-.90
Intervention 4			3.04	0.71	-	-	-	-

Note. * Significant at p= <0.05. ** Significant at p= <0.01. Intervention 1 = employee-led, work-related. Intervention 2 = organisation-led, work-related. Intervention 3 = employee-led, work independent. Intervention 4 = organisation-led, work independent.

allowed for the identification of significantly different ratings between the interventions along the criteria of interest. Based on the results of Table 2, participants assigned significantly different ratings to the interventions across all criteria of interest, namely intention to participate ($F=50.85$, $p< .01$, $\eta_p^2=.68$), belief in sustained participation ($F=14.00$, $p< .01$, $\eta_p^2=.37$), perceived effectiveness to the individual ($F=29.15$, $p< .01$, $\eta_p^2=.56$), and perceived effectiveness to the organisation ($F=102.33$, $p< .01$, $\eta_p^2=.81$). Post-hoc analyses show intervention 4 (organisation-led, work-independent) received significantly lower ratings than the other intervention design types.

Intention to participate. Intervention 4 (organisation-led work-independent) was rated significantly lower than the other three interventions with regard to intention to participate (Table 1). Hypothesis 1, stating that intention to participate in wellbeing interventions would be significantly higher for employee-led, work embedded interventions than for other intervention designs is not supported. However, the post-hoc analysis results displayed in Table 2 indicate that employees are significantly less inclined to participate in organisation-led, work-independent wellbeing interventions (M4=3.21) than in any other intervention type (M1=4.08, M2=4.20, M3=4.09).

Belief in sustained participation. Intervention 4 was rated significantly lower than the other interventions with regard to belief in sustained participation (Table 2). Hypothesis 2, stating that intention to sustain participation would be significantly higher for employee-led, work embedded interventions than for other intervention designs is not supported. However, the post-hoc analysis results (Table 2) indicate that employees are significantly less inclined to sustain participation in organisation-led, work-independent wellbeing interventions (M4=3.16) than in other intervention types (M1=3.81, M2=4.04, M3=3.86).

Perceived effectiveness to the individual. Intervention 4 was rated significantly lower than the other interventions with regard to perceived effectiveness to the individual (Table 2). Hypothesis 3, stating that perceptions of individual level effectiveness will be significantly higher for employee-led, work embedded interventions than for other intervention designs is not supported. However, the post-hoc analysis results (Table 2) indicate that employees perceive organisation-led work-independent wellbeing interventions as less effective to the individual (M=3.01) than other intervention types (M1=3.88), M2=3.90, M3=4.03).

Perceived effectiveness to the organisation. Intervention 4 was rated significantly lower than the other interventions with regard to perceived effectiveness to the organisation (Table 2). Thus hypothesis 4, stating perceptions of organisation level effectiveness will be significantly higher for employee-led, work embedded interventions than for other intervention designs is not supported. However, the post-hoc analysis results (Table 2) indicate that employees perceive organisation-led work-independent wellbeing interventions as less effective to the organisation (M=3.04) than other intervention types (M1=3.95, M2=4.07, M3=4.08).

Intervention ranking

A frequency analysis was run in order to gain insight into rank order differences among interventions. Figure 1 shows that when ranking interventions in order of preference, over 50% of participants ranked intervention 1 (employee-led, work-related) as the most preferred, and almost 80% as either first or second most preferred. Intervention 2 (organisation-led, work-related) received more first ranked votes than intervention 3 (employee-led, work-independent), however intervention 3 has a higher proportion of participants ranking it as the second most preferred, and more joint first and second place rankings than intervention 2.

Overall, this indicates that upon direct comparison of organisation-led, work-related and employee-led, work-independent interventions, employees respond more positively to the latter. Over 50% of the participants rated intervention 4 (organisation-led, work-independent) as their least preferred, and over 80% of participants ranked it last or second-to-last. These results support hypothesis 5 that employee-led, work-related interventions would be ranked as the most preferred. Furthermore, these results clearly demonstrate and further emphasize that intervention 4 is the least preferred among the four interventions. It should be noted that although employee-led, work-related interventions were ranked as most preferred, they did not receive significantly higher scores than the other interventions along the evaluation criteria of interest.

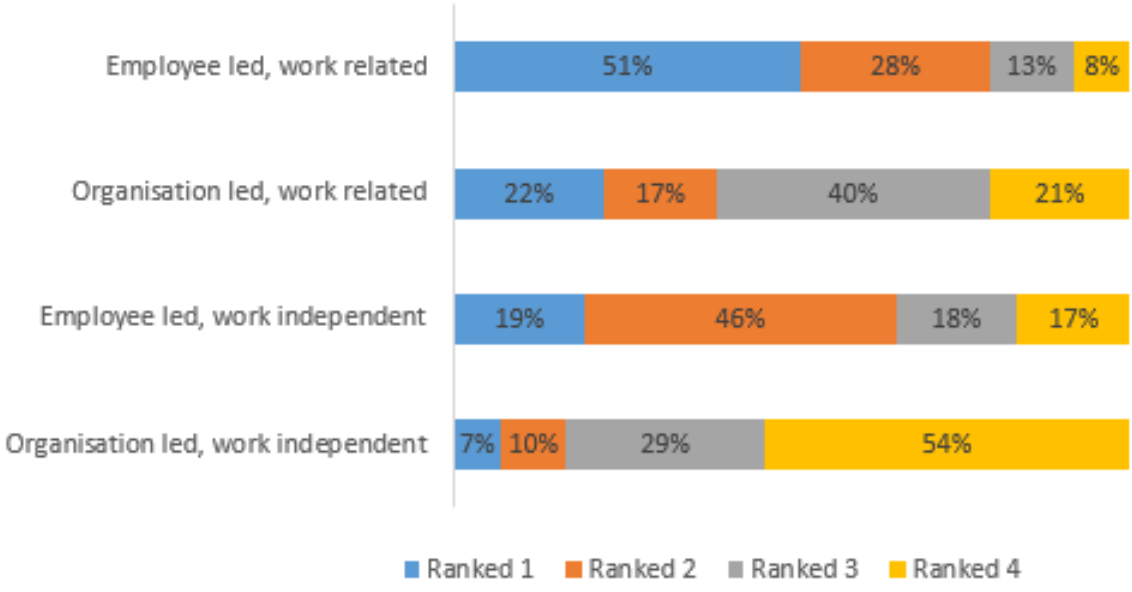

Figure 1. Distribution of intervention ranking order (from most to least preferred)

Discussion

The aim of the current study was to explore how employees view and appraise wellbeing interventions with different design characteristics. Contrary to the hypotheses that work-related, employee-led interventions would be evaluated significantly higher than other intervention designs using the four criteria of intention to participate, belief in sustained participation, effectiveness to the individual, and effectiveness to the organisation, differences in the mean ratings of intervention types showed no clear front-runner. However, the work-independent, organisation-led intervention was rated significantly less favourably in comparison to the other intervention types along all evaluation criteria. Not surprisingly, when interventions were ranked from most to least preferred, a majority of participants ranked the work-independent, organisation-led intervention as their least preferred. In line with what was hypothesised a majority of individuals ranked the work-related employee-led intervention as most preferred.

The results indicate that, of the different wellbeing interventions evaluated, the least likely to be accepted by employees is the organisation-led, work-independent intervention. Specifically, the intention to participate, belief in sustained participation, and views of effectiveness to both the individual and the organisation would be less favourable for this format than other design types. Reasons for this lower rating may be that employees find it unnecessary and intrusive for their organisation to make decisions regarding their health and wellbeing that are unrelated to the work itself. Interventions with minimal participant input and control, particularly those that reflect activities that are not work-related, are more likely to be deemed useless or viewed as wasting important work resources (e.g. time, money). Interestingly, and unfortunately, this least preferred intervention type is the one that is most pervasive in organisations (Kelloway et al., 2008). Not only is this a costly exercise, but it also

could explain the low participation rates reported in literature (e.g. Linnan et al., 2001; Robroek et al., 2009; Street & Lacey, 2018). Conversely, employees show a preference for work-related, organisation-led interventions. The reasoning behind this preference over other intervention types cannot be deduced from the evaluation criteria investigated in the current study. This is due to it not being rated significantly higher than the others on the criteria of interest, meaning alternative elements of this specific design unexplored in the current study make it appealing to employees.

Employees seem to respond positively to work-related interventions, regardless of whether the decision-making and implementation processes are led by the organisation or themselves. Work-related interventions are those in which changes are made to how the work is designed, organised, planned, and managed in order to balance job demands and resources, for example work redesign and team development. Given that these reflect primary interventions, they may be perceived positively by employees as they target the root cause of workplace stressors, rather than stress symptoms. Furthermore, such interventions make sense to employees as they are relevant to the work context and unique challenges employees face. Nevertheless, Kelloway, Hurrell, and Day's (2008) claim that organisational decision-makers may prefer secondary interventions over primary interventions due to the costs and logistics involved with implementing the latter. Given employees seem to prefer primary interventions, organisations may be engaging in a skewed cost-benefit analysis, and consider the immediate costs of the intervention over uptake, sustainability, and effectiveness against wellbeing and performance criteria.

The results also show that employees respond positively to work-independent or secondary interventions, but mostly when they lead the decision-making and implementation processes, rather than the organisation. Work-independent interventions may be well received

due to the stress reduction goals and enjoyment of the initiatives involved (e.g. meditation, exercise) (LaMontagne et al., 2007). Employees may positively respond to leading these interventions themselves, as doing so increases feelings of fairness, justice (Nielsen et al., 2010) respect, and esteem from the organisation (Andersen & Svarer, 2007). Furthermore, employee-organised secondary intervention are more likely to address health and wellbeing issues that are directly relevant to the employee group (Goetzel et al., 2007; Peersman et al., 1998). Employees may also feel empowered in being delegated this responsibility and being granted sufficient control over chosen activities. This is in line with Grawitch, Ballard, and Erb's (2015) argument that high involvement may influence active participation in intervention initiatives.

Overall, the organisation-led, work-independent intervention design type was the least preferred across each of the classification criteria, including intention to participate, belief in sustained participation, effectiveness to the individual, and effectiveness to the organisation, as well as being ranked as the least preferred when compared to the other three types. Conversely, the employee-led, work-related intervention design type was ranked as the most preferred, even if it did not obtain significantly higher scores than the alternatives along the criteria of interest.

The analyses shown in the previous section suggest that individual variables such as gender and age might influence the interpretation of these findings. Regarding gender, women manifest significantly higher preference for work-related, organisation-led interventions compared to men. However, women also have a clear preference for the opportunity to lead interventions that are independent from work. Two possible justifications for these findings concern a) workload management challenges, and b) gendered efficacy beliefs. Regarding the former, it is a tired stereotype that men are the breadwinners and women the housekeepers in traditional families. Yet, a 2017 survey of New Zealanders attitudes toward gender found 21%

of those who said women are generally disadvantaged by gender inequality attributed this to gender stereotypes and expectations still existing (Gender Equal NZ & Research NZ, 2017). This may be due to women's increased participation rate in the workforce not being accompanied by a decrease in household expectations and responsibilities (Chawla & Sharma, 2019). For example, New Zealand mothers tend to be the primary caregiver for their children (Schmidt, 2014), and there exists a gender imbalance with regard to both parenting and domestic labour (Morgan, 2008). Furthermore, over half of individuals surveyed agreed that New Zealand women feel pressured to choose between being a good wife/mother and having a professional or business career (Gender Equal NZ & Research NZ, 2017). Women may hence be less inclined to lead interventions seen as adding to their workload and interfering with demands outside of work, and prefer that the organisation takes over the planning and resourcing stages of job redesign and other primary interventions. Conversely, women may welcome opportunities to engage in social and recreational activities that target wellbeing, which are arguably less time-consuming than primary interventions.

With regards to women's preference for organisation-led, work related interventions, the explanation linked to efficacy beliefs is supported by research by Morrison and Owler (2018) who explored what makes New Zealanders 'love' their work. They found that women tend to enjoy jobs that bring them a sense of competence i.e. where they have the skill, ability, and capacity to do well, in comparison to males who prefer jobs that challenge and stretch them. The researchers attribute this to unconscious bias and gender stereotypes that contribute to women experiencing lower levels of self-efficacy (i.e. belief in one's own ability to succeed in a specific task) and the imposter phenomenon (i.e. feelings of inadequacy or being a fraud, despite evidence of success) more so than men (Morrison & Owler, 2018). As aforementioned, high self-efficacy is a predictor of participation in a wellbeing intervention (Rongen et al.,

2014). This may account for women feeling less inclined to lead work-related interventions, which may be perceived as an added challenge and also infringing more significantly on an already difficult work-life balancing act.

In addition to gender differences, there were also significant associations between age and views of wellbeing interventions. Specifically, younger participants evaluated both work-related and work-independent employee-led interventions as more effective in comparison to older participants. It is important to gain an understanding of different generational needs and values due to an increasingly age diverse workforce (Truxillo, 2015). It has been contended that generations value different things at work. Results from the current study suggest that younger generations respond more positively to wellbeing interventions than older generations, particularly employee-led. Specifically, younger generations evaluate interventions that are employee-led as more effective in comparison to older generations. These findings appear to be in line with those by Grawitch, Trares, and Kohler (2007), who found age to be negatively correlated with satisfaction of employee involvement in interventions. In a New Zealand context Cennamo and Gardner (2011) found younger generations tend to emphasise values related to autonomy, and may be more likely to seek out opportunities to enact these in the workplace. Younger workers prefer autonomy and participation in decision-making in their jobs such that they experience voice and empowered (García et al., 2019; Kong et al., 2016), and thus may be more likely to view employee-led interventions in a positive light. Intergenerational differences may also be attributed to lifecycle stages, whereby younger generations may experience fewer conflicts between work and non-work demands. In this study the ages of participants ranged from 22 to 60, with 60% of participants under the age of 30. These findings not only support the notion of different generations having different

preferences, but also proposes the question of how organisations can aim to meet the varying needs of many generations.

Limitations and directions for future research

The limitations of the current study must be considered alongside the interpretation of its findings. One limitation is sample size. Although the sample size obtained was adequate in detecting statistically significant results, a larger sample would increase statistical power of the research (Field, 2013). Specifically, effects that were significant at the .10 level would have been significant at a more stringent level. Further research should replicate this study using a larger sample size.

For the purpose of survey research, the vignettes had to be short and only vary the critical elements. As seen in Appendix B, specific differences between each vignette were presented in bold in order for participants to more easily distinguish between them. However this may not have been sufficient, given participants did not have the option to compare each intervention as they were presented consecutively. Subsequently, there was no guarantee that individuals could tell the interventions apart from each other. Further research should run manipulation checks.

Another limitation is that this study only takes into consideration participant perceptions of different aspects of wellbeing intervention design at face value, based upon the information they are presented in the vignettes, and disregard prior knowledge and experience concerning wellbeing interventions they may possess (other than whether they previously participated in an intervention). In addition to participant data on their view of specific interventions they have experienced, the study did not include other important pieces of information that may impact evaluations, for example the reported effectiveness of specific

interventions, ease and logistics of implementation, cost, and so on. To address both of these limitations, and to enhance our understanding of preference for intervention design, organisations and researchers may benefit from face-to-face discussions with employees in order to gain qualitative data. Qualitative data allows for a deeper understanding of psychological and social phenomena (DeVellis, 2016). This should involve sitting down with employees to discuss the pros and cons of each intervention type, coming to an understanding of how they evaluate the cost/benefit trade off of each intervention format in order to explore the decision making processes involved. This can give insight into *why* individuals evaluate interventions differently, and may also expand upon the gender and intergenerational differences seen. Such information can then be used to refine quantitative research instruments.

Furthermore, longitudinal research using a quasi-experiment may also influence our understanding of intervention design perceptions. In the present study face value preference is explored, yet intervention evaluations and perceptions may change along the implementation process, and these changes can be captured over time to better account for sustainable engagement with interventions and their effectiveness. In light of this, longitudinal data may give more accurate and substantial results.

Given that employee-led, work related interventions were ranked as preferred, but did not receive significantly higher scores along evaluation criteria than other interventions, a direction for future research may be to ascertain why people prefer this intervention type beyond the criteria explored in this study. Other evaluation criteria of interventions that could be explored might include feasibility, cost effectiveness, or effectiveness in relation to specific outcomes (e.g. engagement, resilience, impact on work, impact on general health).

Future research may also explore cases where both work-related and work-independent intervention activities are implemented in conjunction, as the two are not mutually exclusive. It may be the case that when presented with the opportunity to lead both, one type, or none, employees may be happy to leave work-related activities in the hands of the organisation so long as they have full control over those that are work-independent.

New Zealanders have heightened awareness of wellbeing and wellbeing interventions. Wellbeing is part of social discourse in New Zealand, as evidenced with the recent introduction of a Wellbeing Budget that is based around wellbeing priorities. Furthermore, 2015 saw the amendment of the Health and Safety at Work Act 2015 to include organisations as responsible to individual's physical and mental health (BusinessNZ & Southern Cross Healthcare Society, 2019). Throughout New Zealand there is widespread participation in the Five Ways To Wellbeing, a collection of five evidence based practices (connect, be active, take notice, keep learning, give) found to increase wellbeing (Aked et al., 2009; Hone et al., 2015; Mackay et al., 2019). The Five Ways to Wellbeing has been adopted by the Mental Health Foundation, Health Promotion Agency, and Canterbury's All Right? Campaign as a framework for health and wellbeing promotion. Thus it is likely for New Zealanders to be familiar with wellbeing interventions and their effects, if not first-hand then second-hand. For replication purposes and directions for future research, findings of the current study should be further elaborated on and explored in New Zealand, but also in other places where wellbeing interventions are not as popularised, or at least not as widely discussed as they are in New Zealand.

Theoretical and Practical Implications

The findings from the current study may be of relevance to organisations, practitioners, and academics, given it is the first to explore employee perceptions of different types of

wellbeing intervention design specifically with regard to who leads the intervention (employee vs organisation) and if the intervention activities are related to or independent from the work itself. The results of this study may guide organisations and practitioners regarding which wellbeing interventions to prioritise. The findings highlight that in comparison of interventions of different design combinations individuals least prefer organisation-led, work-independent interventions, and prefer employee-led work-related interventions. Both work-related and work-independent intervention types were perceived as effective by participants, with the exception of when the organisation leads the latter. In contrast, work-related interventions are considered more effective than work-independent interventions in the literature, as these reflect primary level changes to the root causes of work-related stress (Nielsen et al., 2010). It is therefore suggested for organisations and practitioners to invest in work-related over work-independent, or to implement both intervention types in conjunction. Moreover, if organisations are limited in time and resources to implement work-related interventions and thus work-independent interventions are better suited, it is recommended that these be employee-led if possible. In cases where organisations prefer to retain decision making responsibility throughout the design and implementation stages, employees should be as highly involved in these processes as possible (Grawitch et al., 2015). Doing so may foster feelings of ownership over and responsibility for interventions, thus increasing the chance of successful intervention implementation. Further understanding of the reasoning behind preferences may supplement organisations and practitioners with ways in which employee buy-in can be promoted, in particular for organisation-led, work-independent interventions. In this quasi-experiment, views of organisation and employee leadership of interventions were polarised, but it may be that organisation-led interventions with high employee input provide a third, very effective pathway. Doing so alleviates some of the pressure and additional workload involved

in driving interventions, while also ensuring ownership and relevance whilst satisfying employee needs (Nielsen et al., 2007).

This study offers a possible explanation for why current participation levels in wellbeing interventions are so low. Current literature appears to focus on individual and organisational factors affecting participation, for example time constraints and current health status (e.g. Jørgensen et al., 2016; Robroek et al., 2009). These findings highlight that intervention design could be a factor influencing non-participation, given that employee perceptions of interventions are important in determining participation levels (Nielsen et al., 2007). The intervention type that is least preferred by employees in the current study is the type that prevails in organisations (Kelloway et al., 2008). Intervention design may hence be a contributing factor to low participation rates.

The findings of this study identify gender and age differences in perceptions of intervention design. As suggested, women may be disadvantaged by workload challenges and efficacy issues when leading primary interventions. Organisations may benefit from ensuring high access to expert consultants, and managerial support, which is identified as crucial for implementation success (Grawitch et al., 2015), in order to support women in the leading of work-related interventions. Furthermore, leading work-independent interventions may act as a precursor to taking on work-related interventions, as these may result in increased self-efficacy. Organisations that are age diverse may find younger generations respond more positively to interventions, both overall and specifically with regard to those that are employee-led. This emphasises the need for further research surrounding how to meet the needs of various generations in the workplace such that health and wellbeing can be optimised for all.

Conclusion

The current study gives important insight into how employees perceive interventions of varying designs. Employees responded to a survey evaluating interventions that differ with regard to who leads them (employees or the organisation) and if they are related to or independent of work. Evaluation criteria included intention to participate, sustained participation intention, perceived individual effectiveness, and organisational effectiveness. Mean ratings of organisation-led, work-independent interventions were significantly less favourable in comparison to other intervention types. Furthermore, a majority ranked this intervention type as least preferred. These findings provide guidance for practitioners and organisations in how they prioritise interventions and frame wellbeing interventions to employees. Specifically, employees may respond positively to interventions that are work-related regardless of who leads them, and to leading work-independent interventions themselves. By understanding and catering to employee preferences for interventions, participation levels may increase (Street & Lacey, 2018). Employee participation in interventions makes use of important employee knowledge; integrating activities into existing structures and initiatives and ensuring sustainable changes (Nielsen & Randall, 2012). Understanding factors of intervention design that impede or facilitate participation in wellbeing interventions can facilitate the development of more effective and sustainable interventions, and increase cost-benefit ratios (Crump et al., 1996).

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Appendix A: Information and Consent Form

Department of Psychology
Email: elise.mcleod@pg.conterbury.ac.nz
08/05/2019

My name is Elise McLeod, I am a student at the University of Canterbury currently studying toward a Master of Science degree in Applied Psychology. As part of a research project I am **investigating how people perceive and evaluate health and wellbeing interventions** (initiatives, programmes, or practices that aim to improve the physical, psychological, and social wellbeing of individuals). Specifically, I am assessing employee perceptions of, and preference for, different wellbeing intervention designs.

If you choose to take part in this study, your involvement in this project will be to complete an online survey where you will be asked to carefully read and rate a number of different interventions. The survey will take no longer than 20 minutes of your time to complete.

Participation is voluntary and you have the right to withdraw at any stage without penalty. You may ask for your raw data to be returned to you or destroyed at any point. Withdrawal is effected by sampling closing your browser before submitting the data. Once the data has been submitted it cannot be retrieved. There are no foreseen risks associated with survey completion.

The results of the project may be published, but you may be assured of the anonymity of data gathered in this investigation.

If you wish to be put in the prize draw to win one of the five $100 vouchers, or if you wish to receive a summary of the results, your email address will be required so that you may be contacted. In doing so you will be taken to a separate page with no link to the on-line survey, thus preserving anonymity of the data. You may be contacted if you have won one of the $100 vouchers, or if you have requested the results of the study. Data is stored on a password protected external hard drive, and backed up on university servers. Raw data is deleted five years after the project is completed. A thesis is a public document and will be available through the UC Library.

The project is being carried out as a requirement for Masters in Applied Psychology by Elise McLeod, under the supervision of Dr Joana Kuntz, who can be contacted at joana.kuntz@canterbury.ac.nz. She will be pleased to discuss any concerns you may have about participation in the project.

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (humanethics@canterbury.ac.nz).

I have been given a full explanation of this project and have had the opportunity to contact the principal researcher and ask questions.

I understand what is required of me if I agree to take part in the research.

I understand that participation is voluntary and I may withdraw at any time without penalty, by exiting the browser before clicking “Submit”. I understand that once the survey is submitted removal of data will not be practically achievable.

I understand that any information or opinions I provide will be kept confidential to the researcher and supervisors, and that any published or reported results will not identify the participants. I understand that a thesis is a public document and will be available through the UC Library.

I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after five years.
I understand that I can contact the researcher Elise McLeod (elise.mcleod@pg.canterbury.ac.nz) or supervisor Joana Kuntz (joana.kuntz@canterbury.ac.nz) for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz)

I understand that I can request a summary of the results of this project at the end of the survey

By clicking continue, I agree to participate in this research project.

Appendix B: Full Questionnaire

Please indicate if you have previously participated in a workplace wellbeing intervention:

Yes

No

Please carefully read the following text (note small details of each intervention are different)

> Your organisation is offering you and your team the chance to **help design an intervention to improve wellness**. The intervention will consist of a series of initiatives trialled over an 8-week course and participation is entirely voluntary. This will be a collaborative process whereby your organisation will bring in a team of consultants to look into **current work processes and identify ways in which these aspects can be changed to improve wellness in the workplace**. The consultants will be tasked with compiling information and running a brainstorming session with staff where they will be available to offer their expertise, but **ultimately you and your team will decide upon the design and implementation of the initiatives**. Initiatives linked to improved work processes and culture may include introducing walking meetings, designating a space for relaxation, increasing autonomy, introducing more frequent breaks, and so on.

For the following statements, please indicate your level of agreement on the scale provided

Response scale: Five point Likert with anchors “Strongly disagree”, “disagree”, “somewhat agree”, “agree”, “strongly agree”.

If my organisation offered this intervention, I would participate

This intervention would improve my wellness

I can see myself participating in this intervention in the long run

This type of intervention would improve the wellness of my organisation

Please carefully read the following text (note small details of each intervention are different)

> Your organisation is offering you and your team the chance to **partake in an intervention to improve wellness**. The intervention will consist of a series of initiatives trialled over an 8-week period and participation is entirely voluntary. This will be a collaborative process whereby your organisation will bring in a team of consultants to look into **current work processes and identify ways in which these aspects can be changed to improve wellness in the workplace**. You are invited to **fill out a 15-minute survey where you can provide information**

> **concerning current stressors you experience at work along with suggestions for improvement.** The information you provide may be used by the experts to inform changes to work processes. Initiatives linked to improved work processes and culture may include introducing walking meetings, designating a space for relaxation, increasing autonomy, introducing more frequent breaks, and so on

For the following statements, please indicate your level of agreement on the scale provided

Response scale: Five point Likert with anchors "Strongly disagree", "disagree", "somewhat agree", "agree", "strongly agree"

If my organisation offered this intervention, I would participate

This intervention would improve my wellness

I can see myself participating in this intervention in the long run

This type of intervention would improve the wellness of my organisation

Please carefully read the following text (note small details of each intervention are different)

> Your organisation is offering you and your team the chance to **help design an intervention to improve wellness**. The intervention will consist of a series of initiatives trialled over an 8-week period and participation is entirely voluntary. This will be a collaborative process whereby your organisation will provide a team of consultants to look into **current stressors experienced by employees to identify specific activities to be offered to improve wellness in the workplace**. The consultants will be tasked with compiling information and running a brainstorming session with staff where they will be available to offer their expertise, but **ultimately you and your team will decide upon the design and implementation of the initiatives**. Activities to be implemented could include yoga classes, stress management courses, tai chi classes, mindfulness courses, and so on

For the following statements, please indicate your level of agreement on the scale provided

Response scale: Five point Likert with anchors "Strongly disagree", "disagree", "somewhat agree", "agree", "strongly agree"

If my organisation offered this intervention, I would participate

This intervention would improve my wellness

I can see myself participating in this intervention in the long run

This type of intervention would improve the wellness of my organisation

Please carefully read the following text (note small details of each intervention are different)

> Your organisation is offering you and your team the chance to **partake in an initiative to improve wellness**. The initiative will be trialled over an 8-week period and participation is entirely voluntary. This will be a collaborative process whereby your organisation will provide a team of consultants to look into **current stressors experienced by employees to identify specific activities to be offered to improve wellness in the workplace**. You are invited to **fill out a 15-minute survey where you can provide information concerning current stressors you experience at work along with suggestions for improvement**. The information you provide may be used by the experts to inform the specific activities to be implemented. Activities to be implemented could include yoga classes, stress management courses, tai chi classes, mindfulness courses, and so on

For the following statements, please indicate your level of agreement on the scale provided

Response scale: Five point Likert with anchors “Strongly disagree”, “disagree”, “somewhat agree”, “agree”, “strongly agree”

If my organisation offered this intervention, I would participate

This intervention would improve my wellness

I can see myself participating in this intervention in the long run

This type of intervention would improve the wellness of my organisation

Please rank (click and drag) the previous interventions in order of preference (most preferred item at the top)

You and your team decide upon the changes to be made to current work processes

Experts decide upon the changes to be made to current work processes

You and your team decide upon the specific non-work related activities to be implemented

Experts decide upon the specific non-work related activities to be implemented

Which gender do you identify with?

a. Male
b. Gender Diverse
c. Female

Please state your age: _____